REGISTRANT FEE IS $25

APPLICATION FOR HVACR REGISTRANT

Name: _____
Last First Middle

DATE OF BIRTH: _____ **SOCIAL SECURITY NO.** _____

HOME ADDRESS: _____
Street or PO Box City State Zip County

HOME PHONE: ( ) _____

CO. EMPLOYED BY _____ **CO. PHONE** _____

NAME OF LICENSE HOLDER _____

LICENSE HOLDER LICENSE NO. _____

COMPANY ADDRESS _____
Street or PO Box City State Zip County

Have you ever been registered with the HVACR Section of the Arkansas Department of Health before? Yes _____ **No** _____

If yes, under what company name? _____

PREVIOUS LICENSE NO. _____

Return application to:

ARKANSAS DEPARTMENT OF HEALTH
PROTECTIVE HEALTH CODES
4815 W MARKHAM SLOT H-24
LITTLE ROCK AR 72205-3867

* PAYMENT MUST BE INCLUDED IN ORDER TO BE PROCESSED *

ACKNOWLEDGEMENT

By signing this application, I _____ **acknowledge that**
(PLEASE PRINT)
it is my responsibility to keep the HVACR Section of the Arkansas Department of Health advised as to my current address and current employer.

Signed: _____ **Date** _____

Employer Signature: _____

REV (10/31/07)